Example: Provider Name/Address Changes

CERTIFICATE OF INSURANCE

Name and/or Address change to:
Insert new name
Insert new address

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	__50___%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80150		
Limits of Liability $___250,000_____ per occurrence $750,000 annual aggregate	Premium Amount: $18,259 Surcharge Amount: $13,577 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature
Printed: _____
Title: _____

NOTE: Information in body of certificate should be identical to the information originally submitted. New name and/or address should be documented in top right hand corner of certificate.

Example:

CERTIFICATE OF INSURANCE

Provider with assumed business names

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name (see attached listing of assumed business names)** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80999		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $25 Surcharge Amount: $100 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Any health care provider that uses an assumed business name must state the assumed business name on the certificate of coverage filed with the department for the assumed business name to be included in the health care provider's status as a qualified provider defined by IC 34-18-2-24.5. Assumed business names can be filed by attaching a separate sheet of paper to the certificate.

Example: Non-Physician
110% Surcharge

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: **Insert appropriate code from FAQs**		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $200 Surcharge Amount: $220 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature
Printed: _____
Title: _____

NOTE: Health care providers that are not licensed as physicians or hospitals are assessed surcharge at the rate 110% of underlying professional liability premium or the minimum surcharge of $100, whichever is greater. Premium amount field should only reflect professional liability premium for Indiana exposure.

Example: Non-Physician
Minimum surcharge

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: **Insert appropriate code from FAQs**		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $25 Surcharge Amount: $100 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Health care providers that are not licensed as physicians or hospitals are assessed surcharge at the rate 110% of underlying professional liability premium or the minimum surcharge of $100, whichever is greater. Premium amount field should only reflect professional liability premium for Indiana exposure.

Example: Non-Physician # CERTIFICATE OF INSURANCE **County Changed to St. Joseph**

Return/Additional Surcharge

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☒	$__(47)___	____03/01/06__
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence ☐ Claims Made ☒ Reporting ☐ Endors.	Retro Date __06/26/04_____ Retro Date _____	
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒	Excluding employees ☐	
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80211		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $1,243 Surcharge Amount: $1,267 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Information in body of certificate should be identical to the information originally submitted. Return/additional surcharge information is to be documented in top right hand corner only by marking return/additional surcharge, inserting return or additional surcharge amount, effective date and reason for return/additional surcharge.

Example: Physician

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence ☐ Claims Made ☒ Reporting ☐ Endors.	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒	Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**	
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: **Insert appropriate code from Rule 60**	
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $18,259 Surcharge Amount: $27,155 Penalty Amount:	

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Surcharge for physicians is determined by effective date of underlying coverage, ISO Code per Rule 60 and corresponding surcharge rate per the applicable Bulletin issued by Commissioner. Rules and Bulletins can be accessed at www.in.gov/idoi/medmal.

Example: Physician

CERTIFICATE OF INSURANCE

Credit Applied, Pro-rated or Retired

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	__50___%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: **Insert appropriate code from Rule 60**		
Limits of Liability $___250,000_____ per occurrence $750,000 annual aggregate	Premium Amount: $18,259 Surcharge Amount: $13,577 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: If credit is applied to surcharge the percentage of credit must be documented in top right hand corner by marking credit, inserting percentage amount (25%, 50%, 67%, 75%) and reason (0-10 hrs, 11-20 hrs faculty, 1st yr practice, 2nd yr practice). Surcharge amount field should reflect the adjusted amount. If no credit is applied, but pro-rated or retired, please note on the certificate. If surcharge varies from amount owed and no explanation is provided, PCF system will not accept.

Example: Physician # CERTIFICATE OF INSURANCE **Changing ISO code to 80115**

Return/Additional Surcharge

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☒	$__(2,152)	____03/01/06__
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80143		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $19,779 Surcharge Amount: $15,870 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Information in body of certificate should be identical to the information originally submitted. Return/additional surcharge information is to be documented in top right hand corner only by marking return/additional surcharge, inserting return or additional surcharge amount, effective date and the reason for return/additional surcharge.

Pac-3/State Form 2713R5
Revised 4/17/05

Example: Cancellation
Minimum Surcharge Paid

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☒	$0____	_____03/02/06
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80211		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $25 Surcharge Amount: $100 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

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Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Information in body of certificate should be identical to the information originally submitted. Cancellation information is to be documented in top right hand corner only by marking cancellation, inserting return surcharge amount and effective date. If minimum surcharge was remitted that amount is considered earned.

Pac-3/State Form 2713R5
Revised 4/17/05

Example: Cancellation
Return Surcharge

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☒	$(347)____	_____03/02/06
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence Claims Made Reporting Endors.	☐ ☒ ☐	Retro Date __06/26/04_____ Retro Date _____
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒		Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**		
Coverage Dates: From: _____06/26/05__ To: _____06/26/06___	Classification Number: 80211		
Limits of Liability $___250,000_____ per occurrence $____750,000____annual aggregate	Premium Amount: $866 Surcharge Amount: $952 Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Information in body of certificate should be identical to the information originally submitted. Cancellation information is to be documented in top right hand corner by marking cancellation, inserting return surcharge amount and effective date. If minimum surcharge was remitted that amount is considered earned.

Example:

CERTIFICATE OF INSURANCE

Reporting Endorsement (Tail Coverage)

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence ☐ Claims Made ☐ Reporting Endors. ☒	Retro Date _____ Retro Date ____06/26/04___
Health Care Provider: **Insert Full Name** Medical License No.: **Active Indiana # issued by Professional Licensing Agency**	Including employees ☒	Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**	
Coverage Dates: From: 06/26/04 (Same as retro date)__ To: 03/02/06_(End date of coverage and/or cancellation date)	Classification Number: **Insert appropriate code from Rule 60**	
Limits of Liability $___250,000_____ per occurrence $750,000 annual aggregate	Premium Amount: $ Surcharge Amount: $ Penalty Amount:	

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____
Title: _____

NOTE: Information that should be modified from the orignal information submitted is coverage type, coverage dates, premium and surcharge amounts. Please refer to the FAQs on the Department's website to determine how surcharge is calculated for a reporting endorsement (tail coverage).

Pac-3/State Form 2713R5
Revised 4/17/05

Example: Nursing Home # CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence ☒ Claims Made ☐ Reporting Endors. ☐	Retro Date _____ Retro Date _____
Health Care Provider: **Insert Full Name as Department of Health License reflects** Medical License No.: **# issued by Dept. of Health**	Including employees ☒	Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**	
Coverage Dates: From: _____To: _____	Classification Number: **Insert appropriate code from FAQs**	
Limits of Liability $___250,000_ per occurrence $ **See Note Below** annual aggregate	Premium Amount: $20,000 Surcharge Amount: $22,000 Penalty Amount:	

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

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Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature
Printed: _____
Title: _____

NOTE: Nursing Homes are assessed surcharge in the same manner as health care providers that are not licensed as physicians or hospitals. The annual aggregate should be $750,000 (0-99 licensed beds) or $1,250,000 (100+ licensed beds). Adjustments for nursing homes should be reported in the same manner as health care providers that are not licensed as physicians or hospitals.

Example: Hospital

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.: DP5176 BV721189	Occurrence ☒ Claims Made ☐ Reporting Endors. ☐	Retro Date _____ Retro Date _____
Health Care Provider: **Insert Full Name as Department of Health License reflects** Medical License No.: **# issued by Dept. of Health**	Including employees ☒	Excluding employees ☐
Address (Street, City, State, Zip): 6249 South East Street, Ste, I Indianapolis, IN 46227	County: **Principal County of Practice**	
Coverage Dates: From: _____To: _____	Classification Number: **Insert appropriate code from FAQs**	
Limits of Liability $___250,000_ per occurrence $ **See Note Below** annual aggregate	Premium Amount: $20,000 Surcharge Amount: $Insert amount calculated from hospital calculation sheet Penalty Amount:	

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is One Hundred and Ten Percent (110%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

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Dated this ____ day of _____, 20___ at the insurance office of **Insert Licensed or Authorized Insurance Carrier Name**

Signed by: **Co. Representative or Indiana Licensed Surplus Lines Agent for Surplus Lines Carrier**
Authorized Signature

Printed: _____

Title: _____

NOTE: Surcharge for hospitals is determined by effective date of underlying coverage and corresponding hospital calculation sheet per the applicable Bulletin issued by Commissioner. Rules and Bulletins can be accessed at www.in.gov/idoi/medmal . The annual aggregate should be $5,000,000 (0-99 licensed beds) or $7,500,000 (100+ licensed beds).